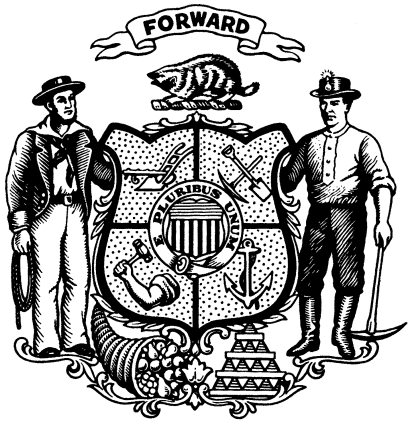
Comment draft

Family Care Audit Guide

CFDA # 93.778

A supplement to the Provider Agency Audit Guide and to the State Single Audit Guidelines for Resource Centers and Care Management Organizations participating in the Family Care Program



2004 Revision

Family Care Audit Guide
2004 Revision

Summary of changes in this revision

Section		Description of changes
1.3	Entities operated by local governemnts	• Deleted reference to Community Supported Living Arrangements
1.4	Effective date	• Noted that the 2004 revision is effective for years ending on or after 12/31/04.
1.8	Where to send the audit report	• Changed address
1.9	Questions on audit requirements	• Added a Resource Center contact person.
2.1	Accounting requirements/Annual Expenditure Report	• Clarified audit procedure by listing specific report to review.
2.2	Medicaid cost center for I&A	• Corrected reference to CARS profile 1401 to be 1402 and added an audit procedure to check reasonableness.
2.3	Functional screen federal financial participation (FFP)	• Added reference to profile 1432. • Added audit procedures to verify hourly rate and a comparison of the number of screens.
3.1	General accounting requirements	• Added more detailed audit procedures to determine compliance with GAAP
3.2	Capitation Receivable	• Added compliance requirements audit procedures
3.3	Cost Share Receivable	• Added compliance requirements and audit procedures.
3.4	Client Funds	• No wording changes, renumbered section only.
3.5	Fixed Assets	• Added compliance requirements and audit procedures.
3.6	Incurred but not reported provider claims	• Added compliance requirement information. • Added audit procedures and included examples to assist auditor in understanding this “insurance” concept.

3.7	Capitation Unearned	• Added compliance requirement and audit procedure.
3.8	Capacity for financial solvency and stability	• Added audit procedures
3.9	Capitation Revenue	• Added audit procedures to verify incurred revenue.
3.10	Care Management Services	• Added compliance requirement and audit procedures.
3.11	Administrative Expense	• Added audit procedures.
3.12	Encounter	• Added compliance requirements and audit procedures.
3.13	Audits of service providers	• Renumbered.

Sections deleted
- Third Party Liability (TPL)
- Risk Sharing
- Payments to providers

Sections added
- Capitation Receivable
- Fixed Assets
- Capitation Unearned
- Care Management Services
- Encounter/Data Certification

Updated audit procedures
- General accounting requirements
- IBNR
- Capacity for financial solvency
- Capitation Revenue
- Administrative Expenses

Family Care Audit Guide
2004 Revision

A supplement to the Provider Agency Audit Guide and to the State Single Audit Guidelines for Resource Centers and Care Management Organizations participating in the Family Care Program

Forward

This audit guide covers audit requirements for Resource Centers and Care Management Organizations participating in Family Care.

The following overview of Family Care is from the department's website at http://www.dhfs.state.wi.us/LTCare/INDEX.HTM:

Family Care is a flexible long term care (LTC) benefit authorized by 1999 Wisconsin Act 9. The goals of Family Care are to increase consumer choice, improve access to services, create a comprehensive and flexible long-term care service system, improve quality through a focus on health and social outcomes, and create a cost effective system for the future.

Family Care will foster recipients' independence and quality of life, while recognizing the need for interdependence and support. This major redesign of the state's long-term care system has three major components:

- Aging and Disability Resource Centers, where older people and people with disabilities and their families can get information and advice about a wide range of resources available to them in their local communities.
- The Family Care benefit, which combines funding from a variety of existing programs into one flexible long term care benefit covering a wide variety of services and supports, tailored to each individual's needs, circumstances and preferences.
- Care Management Organizations (CMOs), which will manage and deliver the new Family Care benefit under a capitated managed care risk model.

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Family Care Audit Guide
2004 Revision

A supplement to the Provider Agency Audit Guide and to the State Single Audit Guidelines for Resource Centers and Care Management Organizations participating in the Family Care Program

1 Introduction

In this document,

Care Management Organization means an organization that has been certified by the department as outlined in the Health and Community Supports Contract to make available to members, in consideration of monthly capitated payments, certain long-term care and health care services. Under the terms of the risk-based Health and Community Supports Contract, the CMO receives a prospective payment per member per month and is responsible for performing comprehensive assessments, developing interdisciplinary care plans, delivering services either directly or through contracted providers, and monitoring consumer outcomes. The per member per month capitation also includes an administrative component which covers such functions as provider contracting and quality monitoring, fiscal support, information technology and business systems development, claims payments and other administrative support.

Department means the Wisconsin Department of Health and Family Services.

Resource Center means an entity under contract to the department to provide services specified in its Aging and Disability Resource Center contract with the department. Resource Centers provide "one stop shopping" for information about and assistance accessing the long-term care system. They are also charged with performing Pre-Admission Consultation to individuals entering the long-term care system via residential settings, to assist these individuals in making informed and cost-effective decisions about meeting their long term care needs. Resource Centers also determine functional eligibility for the Family Care benefit available from CMOs and enroll eligible individuals in the CMO.

Service Provider means an entity under contract to the Care Management Organization to provide specified services to members of the Care Management Organization.

1.1 Applicable audit standards

Audits of agencies participating in the Family Care Program shall be performed in accordance with the following standards:

1. Generally accepted auditing standards, established by the American Institute of Certified Public Accountants, including consideration of fraud. See Chapter 6 of the *Provider Agency Audit Guide* for guidance on consideration of fraud in a government contract environment.

2. *Government Auditing Standards*, established by the United States General Accounting Office.

3. The department's audit standards in:
   a. The *State Single Audit Guidelines* (online at www.ssag.state.wi.us) for audits of local governments which are in accordance with OMB Circular A-133 "Audits of States, Local Governments, and Non-Profit Organizations" based on other funding received by the agency (see Section 1.2).

      or

   b. The standards for agency-wide audits in the *Provider Agency Audit Guide* (online at www.dhfs.state.wi.us/grants) for all other agencies, including:
      - Non-profit organizations, whether or not they also need to have audits in accordance with OMB Circular A-133.
      - For-profit organizations.
      - Local governments that do not need to have audits in accordance with OMB Circular A-133, and thus are not subject to the *State Single Audit Guidelines*.

4. The audit standards in this *Family Care Audit Guide,* which describes compliance requirements specific to the Family Care Program, supplementing the following sections in the department's audit standards:
   - The Compliance Requirements in Section 5 the *Provider Agency Audit Guide.*
   - The DHFS audit requirements in Appendix F435 of the *State Single Audit Guidelines.*

1.2 OMB Circular A-133 is not applicable

The department does not consider the Family Care Program to be federal financial assistance. Therefore, the requirements of OMB Circular A-133 "Audits of States, Local Governments, and Non-Profit Organizations" are not applicable based on funding for the Family Care Program. However, agencies must have A-133 audits if they meet the requirements for such an audit based on funding other than the Family Care Program.

1.3 Entities operated by local governments

If a Family Care entity is governed by a single county, the audit of the Family Care entity may be a part of the county's annual audit, which is performed in accordance with the *State Single Audit Guidelines* and the *Family Care Audit Guide.* The Family Care Program is the equivalent of a named state major program for purposes of audit testing.

The *State Single Audit Guidelines* identify certain programs to be named state major or Type A programs, including several which might be administered through Family Care:

- Community Options Program (designated major)
- Case Management Agency Providers (designated Type A)
- Community Integration Program II/Community Options Program Waiver (designated Type A)

- Community Integration Program I and Brain Injury Waiver (a program cluster) (designated major)
- Medicaid Personal Care Program (designated Type A)
- Community Services Deficit Reduction Benefit (designated Type A)

The audit requirements in the *State Single Audit Guidelines* for these programs remain in effect as long as the programs continue to operate, even in a county that also is operating a Family Care Management Organization.

1.4 Effective date

The *Family Care Audit Guide* is to be used for audits of Resource Centers and Care Management Organizations participating in the Family Care Program for years ended on or after December 31, 2004.

1.5 Updates to the Family Care Audit Guide

The *Family Care Audit Guide* and all updates are on line at www.dhfs.state.wi.us/grants. Auditors should check for updates at this website as part of audit planning.

1.6 When the audit report is due

The audit report is due to the department within 180 days of the end of the agency's fiscal period. However, if the family care entity is audited as a part of a county audit, the deadline for the family care entity's audit is the deadline for the county audit, which is nine months from the end of the fiscal period.

1.7 What to include in the audit report

At a minimum, the audit report materials that an agency sends to the department shall include the following elements:

- The auditor's opinion on the financial statements of the agency.
- The financial statements of the agency and the financial statement notes and disclosures pertaining to the Family Care resource center and/or the CMO thereto.
- The auditor's report on the agency's compliance and internal controls based on the financial statement audit performed in accordance with *Government Auditing Standards.*
- Assurance that the audit was performed in accordance with the requirements of the *Provider Agency Audit Guide* or the *State Single Audit Guidelines*. This assurance may be in the form of a separate report on compliance with the requirements of the *Provider Agency Audit Guide* or the *State Single Audit Guidelines* or reference to the appropriate document in the report on internal controls and compliance that is required for the audit performed in accordance with *Government Auditing Standards.*
- Assurance that the audit was performed in accordance with the requirements of the *Family Care Audit Guide.* This assurance may be in the form of a separate report on compliance with the requirements of the *Family Care Audit Guide* or reference to the guide in the report on internal controls and compliance that is required for the audit performed in accordance with *Government Auditing Standards.*

- The schedule of findings and questioned costs.
- The schedule of prior year findings.
- The management letter (or similar document conveying auditors' comments issued as a result of the audit) or written assurance a management letter was not issued as a result of the audit.
- The agency's corrective action plan for all findings in the audit report and the management letter, if one was issued.

For Resource Centers and CMOs operated by counties, these report elements may be incorporated into the respective report elements for the county's audit report.

1.8 Where to send the audit report

Send two complete copies of the audit report to the Department of Health and Family Services at the following address:

Program Evaluation and Audit Section
Office of Strategic Finance
Department of Health and Family Services
1 West Wilson Street
P.O. Box 7850
Madison, WI 53707-7850

1.9 Questions on audit requirements

Questions on audit requirements for the Family Care Program can be referred to the department at the address listed above or by contacting the department by phone or e-mail:

CMO contact person:	Linda Baldowin
Telephone:	(608) 261-8885
Email:	baldolc@dhfs.state.wi.us
Resource Center contact person:	Paul Hillman
Telephone:	(608) 266-5149
Email:	hillmpw@dhfs.state.wi.us

2 Compliance Requirements for Resource Centers

The following overview of Resource Centers is from the department's website at http://www.dhfs.state.wi.us/LTCare/INDEX.HTM:

Aging and Disability Resource Centers offer "one-stop shopping" to the general public with a focus on issues affecting older people, people with disabilities, or their families. These Centers are welcoming and convenient places to get information, advice and access to a wide variety of services. As a clearinghouse of information about long term care, they will also be available to physicians, hospital discharge planners, or other professionals who work with older people or people with disabilities. Services will be provided through the telephone or in visits to an individual's home. Detailed descriptions of the services the Resource Centers provide are contained in the Resource Center Contract (on line at http://www.dhfs.state.wi.us/LTCare/pdf/RCContract.pdf). A more general description of the services they provide follows:

- **Information and Assistance.** Providing information to the general public about services, resources and programs in areas such as: disability and long-term care related services and living arrangements, health and behavioral health, adult protective services, employment and training for people with disabilities, home maintenance, nutrition and Family Care. Resource Center staff will provide help to connect people with those services and to also apply for SSI, Food Stamps and Medicaid as needed.

- **Long Term Care Options Counseling.** Offering consultation and advice about the options available to meet an individual's long-term care needs. This consultation will include discussion of the factors to consider when making long-term care decisions. Resource Centers will offer pre-admission consultation to all individuals entering nursing homes, CBRFs, adult family homes and residential care apartment complexes to provide objective information about the cost-effective options available to them. This service is also available to other people with long-term care needs who request it.

- **Benefits Counseling.** Providing accurate and current information on private and government benefits and programs**.** This includes assisting individuals when they run into problems with Medicare, Social Security, or other benefits.

- **Emergency Response.** The Resource Center will assure that people are connected with someone who will respond to urgent situations that might put someone at risk, such as a sudden loss of a caregiver.

- **Prevention and Early Intervention.** Promote effective prevention efforts to keep people healthy and independent. In collaboration with public and private health and social service partners in the community, the Resource Center will offer both information and intervention activities that focus on reducing the risk of disabilities. This may include a program to review medications or nutrition, home safety review to prevent falls, or appropriate fitness programs for older people or people with disabilities.

- **Access to the Family Care Benefit.** For people who request it, Resource Centers will coordinate a functional and financial eligibility determination to assess the individual's level of need for the Family Care benefit. Once the individual's level of need is determined, the Resource Center will provide advice about the options available to him or her – to enroll in Family Care, stay in the Medicaid fee-for-service system (if eligible), or to privately pay for services. If the individual chooses Family Care, the Resource Center will enroll that person in the Care Management Organization (CMO). The level of need determined by the Resource Center will also trigger the monthly capitation payment amount to the CMO for that person.

Unless otherwise indicated, all compliance requirements discussed in this section are based on the Department of Health and Family Services and Aging and Disability Resource Center contract for calendar year 2004. The auditor should refer to the actual contract and any supplementary materials when assessing how a requirement applies to a particular Resource Center.

2.1 Accounting requirements/annual expenditure report

Compliance Requirement: The standard Resource Center contract for calendar year 2004 requires, in Article V, Section B, Paragraph 1, the Resource Centers to maintain uniform double entry, full accrual accounting system and a financial management information system in accordance with Generally Accepted Accounting Principles (GAAP). In Article IV, Section H, Subsection 1, the Resource Centers are required to submit an annual expenditure report describing the amount of funds spent on each Resource Center function and the use of funds by categories as determined by the Department. This report shall include a narrative section describing non-client specific activities undertaken by the Resource Center. Categories are identified on the annual expenditure report form.

Suggested Audit Procedures: Sample Resource Center transactions and review accounting policies and procedures to determine compliance with the Resource Center contract and generally accepted accounting principles. Review the annual expenditure report to determine accuracy and consistency with CARS reporting/DMT-862, CARS 610 and the internal general ledger accounting records.

2.2 Medicaid cost center for information and assistance activities

Compliance Requirement: The Aging and Disability Resource Center contract for calendar year 2004 requires the Resource Center to maintain what can be termed an Information and Assistance Program Cost Center in order to claim Medicaid Funds. Article VI, Section B provides, in its entirety, as follows:

> In order to claim Medicaid funds, each Resource Center shall establish a separate information and assistance program cost center in the accounting records. This cost center will include all costs related to performing information and assistance **except** the following:
>
> - Activities funded with other federal dollars such as Older Americans Act funds or Medicaid Administrative Pass Through (MAPT) funds, Resource Center brief or short-term services, follow-along or service coordination.

- Activities that are service activities billable to other sources such as Medicaid Case Management.

Costs charged to the Information and Assistance Program Cost Center are based on 100% time reporting. The time reporting should be captured in the Time Report Section of the monthly Information and Assistance Reports that the Aging and Disability Resource Center contract requires, in Article IV, Section H, Subsection 1, the Resource Center to submit to the Department.

The Information and Assistance Program costs are reported to the State via the Community Aids Reporting System (CARS) on profile number 1401. The Department then determines the Medicaid portion of the costs by multiplying the reported eligible Information and Assistance Program costs by a certain percentage. The percentage that the Department uses is based on the ratio of the number of the elderly and disabled who are on Medicaid in the county in which the Resource Center is operating to the total number of the elderly and disabled in that county. The calculated Medicaid portion of the costs is then allocated to profile 1402 for reimbursement to the Resource Center.

Suggested Audit Procedures:

- Compare the costs reported in the CARS reports on profile number 1401 for Information and Assistance Program with the time reported in the Time Report Section of the monthly Information and Assistance Reports in order to determine whether the costs claimed in the CARS reports seem accurate and complete. Note that costs reported on CARS may include items such as mileage reimbursement and supplies that will not be reflected on a time report. (The Department can provide copies of the monthly Information and Assistance reports to auditors should they need such copies.)

- Ensure that expenditures reported on CARS profile 1402 were not also reported on CARS profile 1400.

- Review the time reported in the Time Report Section of the monthly Information and Assistance Reports to make sure that this time does not include activities funded in whole, or in part with federal dollars which may include, but are not limited to, those available through the Older Americans Act or Medicaid Administrative Pass Through (MAPT).

- Review monthly expenditures for reasonableness and consistency. If material fluctuations exist, determine the source by doing a more extensive review.

2.3 Functional screen federal financial participation (FFP)

Compliance Requirement: Resource Centers operating in counties that also operate Care Management Organizations are eligible to receive federal payments to offset 50% of the costs of administering functional screens if those screens are used to determine an individual's eligibility for the Medicaid program. For eligible entities, a Resource Center Functional Screen Addendum is attached to the Aging and Disability contract for 2004. It provides in part, as follows:

> …These funds will be used to administer functional screens at the Resource Center. The functional screen must be used to determine an individual's functional eligibility for the family care benefit.
>
> Functional Screen Program costs include those identified in Attachment 1 to this Addendum and are limited to the salary, fringe benefit, and other costs directly attributable to the individual(s) administering functional screens, plus indirect costs that are applied in accordance with a DHFS-approved cost allocation plan. Functional Screen Program activities include those activities necessary to schedule an appointment to administer the functional screen on an individual, travel to and from the appointment scheduled with the individual, interview the individual and administer the functional screen on him or her, make any collateral contacts with the individual's relatives, friends, health care providers or other individuals in order to verify information obtained about the individual through the administration of the functional screen, obtain and review medical records or other documents needed to verify information obtained about the individual through the administration of the functional screen, complete the paperwork and data entry work required to make the functional screen a record stored in a filing system or data base maintained by the Resource Center, and complete the paperwork and data transmission work needed to enable the Resource Center to transmit all or part of the functional screen to the Department, the county economic support unit, a care management organization, or to any other agency of state or federal government that has a need, including a research need, to see all or part of the functional screen and is legally entitled to see all or part of the functional screen.

Costs of functional screens are reported on CARS profile number 1431. The calculated Medicaid portion of the costs is then allocated to profile 1432 for reimbursement to the Resource Center.

Suggested Audit Procedures:

- Compare the authorized FFP hourly reimbursement rate with the actual costs per hour for performing screening activity.

- Verify that the hourly rate was recalculated using prior year actual costs.

- Compare number of screens administered and the time per screen with the figures reported to the Department. (The Department can provide this information to auditors.) Ensure reimbursement is taken only in connection with screens used to determine Medicaid eligibility.

- Ensure that expenditures reported on CARS profile 1432 were not also reported on CARS profile 1400.

- Review monthly hours for reasonableness and consistency. If material fluctuations exist, determine the source by doing a more extensive review.

3 Compliance Requirements for Care Management Organizations

The following overview of Care Management Organizations is from the department's website at http://www.dhfs.state.wi.us/LTCare/INDEX.HTM:

In addition to increasing access to services, a goal of Family Care is to improve the coordination of LTC services by creating a single flexible benefit for all long-term care (LTC) services. Care Management Organizations will cover specific LTC services offered by Medicaid, as well as services in the Home and Community-Based Waivers and the very flexible Community Options Program benefit. For a list of the services that must be offered by CMOs, refer to the description of the long-term care benefit package in the Health and Community Supports Contract (on line at http://www.dhfs.state.wi.us/LTCare/pdf/CMOcontract.pdf).

Care Management Organizations (CMOs) will receive a per person per month capitation payment to manage care for recipients who are living in their own homes, group living situations, or nursing facilities. CMOs will:

- Develop and manage a comprehensive network of long-term care services and supports, and deliver some services directly through CMO staff.
- Conduct a comprehensive assessment of individual's needs, abilities, preferences and values with the consumer and family/guardian. The Care Management Team, consisting of at least a social service coordinator and registered nurse, the member, and informal supports jointly participate in completing a comprehensive assessment which looks at areas such as: activities of daily living, physical health, nutrition, autonomy and self determination, communication, and mental health and cognition.
- Design a care plan in partnership with the consumer, which is based on information gathered during the comprehensive assessment and is tailored to the individual's needs, preferences and outcomes.
- Be responsible for the quality of care and services consumers receive, and for continually improving the quality of care and services.
- Receive a monthly, per person capitation payment for each enrollee based on functional need.

Unless indicated otherwise, all compliance requirements in this section are based on the Health and Community Supports contract between the department and CMOs. The auditor should refer to the actual contract and any supplementary materials when assessing how a requirement applies to a particular CMO. **Since this is a risk-based managed care program, it would also be helpful for the auditor to have insurance or managed care audit experience.**

3.1 General accounting requirements

Compliance Requirement: The Health and Community Supports contract for calendar year 2004 requires, in Article X., Section B, Paragraph 2, the CMO maintain a full accrual accounting system in accordance with Generally Accepted Accounting Principles (GAAP).

Suggested audit procedures:

- Sample accounting transactions to determine compliance with Generally Accepted Accounting Principles. Some suggested verification samples:
  - Check for accrual of administrative expenses incurred but not paid. Legal, audit, third party administrators, consulting fees, and other general administrative expenses are examples of services, which may have been incurred but not paid.
  - Check for accrual of Wages and Benefits incurred but not paid.
  - Check for expenses paid in advance which should be classified as a prepaid asset rather than an expense. Examples may include insurance or payments made in advance to providers.
  - Verify that appropriate liabilities have been established for contingencies, retirement & vacation benefits, incurred but not reported claims (discussed in detail below) etc.

- Review accounting policies and procedures to assure consistency with generally accepted accounting principles (GAAP).

- Interview the finance manager (lead finance person) to assure they have a working understanding and consistent application of generally accepted accounting principles.

3.2 Capitation receivable

Compliance Requirements: The reliability of the financial statements is largely dependent on the accuracy of the CMO's accounting methodologies and estimates for its Capitation Receivable. Furthermore, management of this revenue source is complex and is critical to the solvency of the CMO. The CMO must develop adequate processes, procedures and systems to accurately track the collection of capitation for each eligible member in a timely fashion. Furthermore, the CMO must understand basic eligibility requirements to coordinate enrollment efforts, recognize capitation revenue as it is receivable and write-off capitation revenue as necessary.

Suggested audit procedures:

- Review the detailed, member by member, month by month capitation receivable report (this should be generated from the database that the CMO is using to reconcile membership/capitation). Sample the report to determined if:
  - The policies related to eligibility are consistently applied.
  - The CMO has taken the appropriate action/coordination in accordance with State & CMO policies, to rectify any enrollment errors, which may be resulting in a delayed capitation receipt.
  - The capitation amount claimed as receivable corresponds to the contracted rate at the appropriate level of care.
  - The capitation receivable should "net" the capitation payable (result of timing and/or overpayments). Verify the reasonableness of the payable portion of the receivable.

- Trace a sample of members claimed as receivable from the prior year report to the EDS remittance payment report to verify receipt.

- Determine the reasonableness of prior year receivable by comparing the prior year estimated receivable to a report of capitation received and deposited in the audit year for prior year dates of service. This report is similar to a "lag" report and should be able to be generated

from the CMO's capitation revenue system. Refer to the Family Care Audit Guide contact if the CMO is unable to produce this report or if questions.

- Trace a sample of members claimed as receivable for the current year report to subsequent EDS payment remittances to verify receipt.

3.3 Cost share receivable

Compliance Requirement: The CMO is responsible for collection of the member's monthly cost-share as determined by county Economic Support (ES) staff, and to monitor the cost-share/spend down amounts of it's members.

Suggested Audit Procedures:

- Compare member cost-share requirements (use CARES notice and/or CARES monthly Cost Share Report) with amounts billed and collected on the accounts receivable ledger to assure that it is materially balanced (some amounts may vary due to timing, error etc.).

- Review collection activities to verify probability of actual collections as it relates to the receivable estimate and allowance for uncollectible.

- Review cost share receipts posted after year-end to determine the accuracy of the cost share receivable estimate.

3.4 Client funds

Compliance Requirement: A CMO might act as a fiduciary for client funds. Wis. Statutes and the Social Security Administration provide guidance on the responsibilities of fiduciaries.

Suggested Audit Procedures: If the CMO has fiduciary responsibility for client funds, determine whether the CMO:

- Implemented adequate internal controls over client funds, such as segregation of duties for authorizing disbursement of client funds and disbursing those funds.

- Had written authorization from the client or the client's guardian, agent, or designated representative to hold the resident's funds.

- Segregated client funds from the CMO's funds.

- Maintained written records of the client's funds and provided reports of these funds to clients, guardians, agents, or designated representatives.

3.5 Fixed assets

Compliance Requirement: The Health and Community Supports contract for calendar year 2004 requires, in Article X., Section B, Paragraph 2, the CMO maintain a full accrual accounting system in accordance with Generally Accepted Accounting Principles (GAAP). Generally Accepted Accounting Principles require that purchases for items that have a useful life beyond one year should be capitalized and depreciated accordingly. The CMO **may** reflect assets on

their Balance Sheet **if** the assets belong to the CMO enterprise. If the CMO owns its assets (versus assets are County owned), that asset list must be maintained and updated as assets are purchased and disposed of. Note that not all CMO's will reflect fixed assets on their Balance Sheet.

Suggested audit procedures:

- Determine if the CMO has assets that should be reflected on the Balance Sheet and confirm that with the County's treatment of the assets.

- Verify total assets from the CMO's fixed asset/depreciation system/spreadsheet to the Balance Sheet. (note that the assets can only be accounted for in one county fund and would only be recorded on the CMO's books if they are truly assets of the CMO)

- Verify total accumulated depreciation from CMO's fixed asset/depreciation system/spreadsheet to the Balance Sheet.

- Review the calculation of depreciation and accumulated depreciation.

- Inquire of the fiscal staff how asset disposals are communicated and accounted for to assure that the Balance Sheet fixed asset amount is an accurate reflection of the assets owned by the CMO.

- Verify a sample of current year asset purchases to the source documents (invoice, cancelled check etc.)

3.6 Incurred but not reported provider claims (IBNR)

Compliance Requirements: The reliability of the financial statements is largely dependent on the accuracy of the CMO's accounting methodologies and estimates for its incurred but not reported (IBNR) provider claims. Each CMO has been instructed to develop and monitor it's own methodology based on their expertise of their unique claims paying systems. It has been suggested to the CMO's that they develop more than one method to assist them in estimating IBNR as accurately as possible. The managed care industry in general has learned that although a single methodology may hold fairly accurate in any given year, anomalies can and do occur and can sometimes cause an estimate to be materially under or over estimated. Furthermore, the monitoring of the methodology becomes absolutely necessary to be able to refine methodologies as systems and procedures change but also to be able to disclose material variances from estimated IBNR (especially prior year).

Suggested audit procedures:

- Some CMO's include claims that have been entered into the claims system but have not been paid as part of IBNR. Verify this payable to the source document and check the IBNR calculation to assure that these payables have not been "double counted".

- Review prior year IBNR methodology and estimate by comparing the prior year IBNR by month to claims paid (by date of service) by month. This is referred to as a lag or sometimes called a triangle. For example:

Prior Year IBNR (2003 accounting) as stated on the prior year Financials equals $5,000,000.
Compare the $5 million estimate to the claims that actually paid out for the prior year dates of service (2003), paid in the audit year (2004). The lag will be similar to this:

		Date of Service		
Paid Date	Jan-Sep-03	Oct-03	Nov-03	Dec-03
Jan-04	$100,000	$200,000	$500,000	$1,000,000
Feb-04	$ 75,000	$150,000	$300,000	$ 650,000
Mar-04	$ 50,000	$ 75,000	$125,000	$ 500,000
Apr-04	$ 25,000	$ 45,000	$ 85,000	$ 130,000
Etc.				
Total	$250,000	$470,000	$1,010,000	$2,280,000
Total paid	$4,010,000			
PY IBNR	$5,000,000			
Total overestimated	$ 990,000			

The overestimated IBNR amount is therefore included as part of the current year incurred. It is important for the CMO's to note this as often times with a material over/under estimate, erroneous conclusions could be drawn based on the member services expenses shown on the Revenue & Expense Statement. For Example:

Member Services as noted on the Revenue & Expense Statement $60,000,000

Without any additional reference, one would erroneously assume that the current year member expenses were approximately $60 million. Once the over/under estimate is disclosed, one could correctly note that current year member expenses are approximately $59,010,000 with a $990,000 benefit of having "over reserved" the IBNR.

The audit work paper would look something like this:

	IBNR as Estimated	Actual per lag	Variance
Dec	$2,500,000	$2,280,000	$220,000
Nov	$1,500,000	$1,010,000	$490,000
Oct	$ 500,000	$ 470,000	$ 30,000
Sep	$ 250,000	$ 250,000	$ 0
Etc.	$ 250,000	$ 0	$250,000
Total	$5,000,000	$4,010,000	$990,000

The Auditor should verify that the over/under prior year estimate is disclosed on the CMO financial statement as a footnote or as a separate line item on the revenue & expense statement.

- Review current year IBNR estimate by reviewing the lag of paid claims (see example above) for current (audit) year dates of service paid after the current year-end (the lag can be run for paid claims through most recent payment date, probably March or April). The audit work paper would look something like this:

	IBNR	Paid Jan	Paid Feb	Paid Mar	Remaining IBNR
Dec	$3,500,000	$2,250,000	$ 750,000	$ 750,000	($250,000)
Nov	$2,750,000	$1,500,000	$ 500,000	$ 250,000	$500,000
Oct	$ 750,000	$ 500,000	$ 150,000	$ 100,000	$ 0
Sep	$ 250,000	$ 250,000	$ 50,000	$ 25,000	($ 75,000)
Etc.	$ 250,000	$ 75,000	$ 50,000	$ 25,000	$100,000
Total	$7,500,000	$4,575,000	$1,500,000	$1,150,000	$275,000

In this case, there are some under reserved months and other months that have adequate IBNR to cover future claims. The auditor needs to work with the CMO to revise or agree with the estimate. The auditor should encourage the CMO to re-estimate the IBNR if the analysis shows a material variance to the initial estimate. A sample work paper is below:

	IBNR	Remaining IBNR	Estimated Revised IBNR
Dec	$3,500,000	($250,000)	$4,000,000
Nov	$2,750,000	$500,000	$2,500,000
Oct	$ 750,000	$ 0	$ 850,000
Sep	$ 250,000	($ 75,000)	$ 375,000
Etc.	$ 250,000	$100,000	$ 200,000
Total	$7,500,000	$275,000	$7,825,000

Analysis should be used to "re-estimate" and support the work paper but the point is that each month should be evaluated individually because months of "over estimate" do not necessarily offset the months of "under estimate" or vice versa.

- In reviewing the current and prior year IBNR, the auditor should assess the reasonability of the method utilized by the CMO to estimate and subsequently adjust its IBNR. The State has recommended that the CMO's use detailed methodologies for example, percent of completion by service categories by month, PMPMs by service category by month and/or service authorization to paid claims by service category by month.

3.7 Capitation unearned

Compliance Requirements: The capitation payments are made in advance, thus generating unearned revenue for the CMO's.

Suggested audit procedures:

- Trace the total unearned revenue to the EDS remittance and status report by totaling the payments associated with future dates of service paid and deposited in the current year.

- Verify the bank deposit/s that corresponds to the unearned revenue.

3.8 Capacity for financial solvency and stability

The contract between the CMO and the department includes provisions for demonstrating that the CMO has capacity to assume the financial risks under the Health and Community Supports contract. The CMO's financial capacity consists of three components:

- Working capital
- Restricted reserve
- Solvency protection

Working Capital
Compliance requirement(s):
The purpose of the working capital is to provide ongoing liquid assets to manage routine fluctuations in revenue and expenses that will occur in the day to day normal course of business operations.

Working capital is the difference between current assets and current liabilities. A CMO's working capital shall not be less than 2% of the projected annual capitation payments from the department to the CMO for the period of the contract.

Suggested audit procedure(s):
- Verify the cash balance to the bank statement if the CMO has a separately identifiable bank account, otherwise, verify the CMO's cash detail to the County to assure that cash balance has been agreed upon by the County (may be able to verify to the County's general ledger balance).

- Verify the classification of assets and liabilities as "current" by reviewing source documents for prepaid expenses, other assets not reviewed elsewhere and other liabilities not reviewed elsewhere.

- Substantiate the current assets and liabilities by reviewing appropriate source documentation. Make a determination that the Balance Sheet assets and liabilities are appropriately classified according to generally accepted accounting principles.

- Compare the working capital (current assets minus current liabilities) to the Health and Community Supports contractual requirements (the auditor should refer to the memo from DHFS that calculates the requirements for the CMO based on the CMO's projected budget).

Risk Reserve
Compliance requirement(s):
The purpose of the restricted reserve is to provide continuity of care for enrolled members, accountability to taxpayers, and effective program administration including the ability to manage the operation of the CMO as a separate and distinct fund with adequate liquid assets to manage volatility of the program.

The CMO shall establish and maintain a separately identifiable reserve account on the chart of accounts to receive the contributions required by contract. Deposits to and withdrawals from the restricted reserve are to be clearly identifiable within the accounting system and supported by documentation of their compliance to the Health and Community Supports contract Addendum III, Section B.

The required minimum balance is an amount set for the term of the contract year, which is based on the annual capitation payment as projected by the CMO and concurred by DHFS. The projection shall be agreed upon between the CMO and DHFS calculated as follows:

- 8% of the first $5 million of annual projected capitation
- 5% of the next $5 million of annual projected capitation
- 3% of the next $10 million of annual projected capitation
- 2% of the next $30 million of annual projected capitation
- 1% of any additional annual projected capitation to a maximum required minimum balance of $2 million.

Any earnings on the restricted reserve account are to remain in the account until the balance reaches the required minimum balance. The CMO may not make disbursements from the restricted reserve account that takes the balance below the required minimum balance, unless it has obtained prior approval from the department for the disbursement. The CMO shall report on the status of the restricted reserve account as part of the financial report that it provides to the Department.

Suggested audit procedure(s):

- Verify the balance of the restricted reserve account reported on the year-end CMO balance sheet to the supporting investment statement.

- Compare the required risk reserve amount (the auditor should refer to the memo from DHFS, which calculates the requirements for the CMO based on the CMO's projected budget) to the actual risk reserve amount and note the adequacy or deficiency.

- Determine whether the CMO had prior approval from the department for any disbursements from the restricted reserve account that brought the balance of the account below the required minimum balance.

Solvency Reserve

Compliance requirement(s):

The CMO is required to provide evidence of solvency protection, which ensures the availability of liquid assets for continuity of care in event the CMO becomes insolvent. This solvency protection may take one of two forms:

1. The county can guarantee that the county is responsible for all financial obligations of the CMO. If the county guarantees responsibility and if the CMO has projected annual capitation payments in excess of $10,000,000, the county must establish a separately identifiable reserve account on the chart of accounts in the amount of $250,000.
2. The CMO may deposit funds into an individual pledged solvency account at a rate to ensure that the balance of the account reached 100% of the required account balance by the beginning of the contract year. The required account balance is:

    - 10% of the first $5 million of annual capitation (minimum balance of not less than $400,000)
    - 5% of the next $5 million of annual capitation

- 2.5% of the next $10 million of annual capitation
- 1% of any additional capitation to a maximum required balance of $2 million

The individual pledged solvency account may be maintained by the Department or by the CMO. If the account is maintained by the CMO, it must be a restricted account.

Suggested audit procedure(s):

- If the CMO chose the first option, determine whether it set aside $250,000 in a separately identifiable reserve account. Compare the amount recorded on the balance sheet to the investment statement.

- If the CMO chose the second option and if it maintained the individual pledged solvency account (as opposed to the department maintaining this account), determine whether the account is a restricted account. Compare the amount recorded on the balance sheet to the investment statement.

- Verify that no withdrawals from the solvency account occurred without the written approval from DHFS (note that the CMO is permitted to withdraw amounts in excess of the requirement without written approval).

3.9 Capitation revenue

Compliance Requirement: In full consideration of services in the LTC benefit package rendered by the CMO, DHFS pays the CMO actuarially determined monthly capitation payments based on the per member per month payment rate specified in Addendum V of the Health and Community Supports contract. Capitation Revenue should be recognized and reflected on the Revenue and Expense Statement on an incurred basis according to generally accepted accounting principles.

Suggested audit procedure(s):

- Verify total capitation accounted for as received to the final EDS remittance report year-to-date capitation paid (regardless of date of service).

- Verify total capitation accounted for as received in the CMO's general ledger system to the CMO's total capitation receipts system/database. Note that each CMO has different systems/databases in place to track capitation received by member but each should be able to generate a report of capitation received by member and this total should then tie to the general ledger as the supporting detail.

- Verify the calculation of incurred capitation revenue to the stated incurred capitation revenue reflected on the Revenue and Expense Statement. The verification work paper for incurred Capitation Revenue should reflect this calculation:

  Capitation received (total received, accounted for and deposited for the calendar year)
  Plus current year Capitation Receivable (see audit procedures above)
  Less prior year Capitation Receivable (as reflected on the prior year Balance Sheet)
  Less current year Capitation Unearned (see audit procedures above)
  Plus prior year Capitation Unearned (as reflected on the prior year Balance Sheet)

3.10 Care management services

Compliance Requirements: Care management services can be an internal allocation and/or a service purchased from a subcontracted vendor/s. In either case, care management service is material program expenditure and is used in rate setting.

Suggested audit procedures:

- Review allocations, methodologies and supporting documentation (this would include wages, benefits, direct expenses of the care management staff and overhead) of care management rates to determine reasonableness.

- Trace the calculated rate to the claims payment system.

- Trace the total care management cost supporting documentation to source documents such as payroll records and review the system rate for reasonableness.

- Verify that Care Management Services are accounted for on an incurred basis by reviewing the accounting procedures to assure that any associated payable has been accrued accordingly.

- In subcontracted situations, trace payments to the contracted rate and claims data.

- Verify the incurred amount on the Profit & Loss statement by calculating:
  Care Management Services paid in the current year for any date of service
  Add Care Management Services incurred but not paid (IBNR)
  Deduct prior year Care Management Services incurred but not paid (IBNR)

3.11 Administrative expenses

Compliance Requirement: Determine if administrative expenses are recorded according to generally accepted accounting principles and that indirect county allocations which are allocated to the CMO are reasonable and consistent.

- Suggested audit procedure(s):Review accrued expenses for appropriateness and **potential unrecorded payables**. Some possible expenses which may need to be accrued include:
  - Wages
  - Benefits
  - Deferred Employee Benefits
  - Legal expenses
  - Audit fees
  - IT consulting services
  - Other consulting services
  - Utilities, etc.

- Verify wage expense to supporting payroll documentation. Trace paid wages to payroll register, add current year accrual for unpaid wages and deduct prior year accrual of wages to total incurred (check this to the Profit & Loss statement).

- Review county indirect allocation processes and procedures for appropriateness and consistency.

- Review administrative expenses for potential capital expenditures, which should be capitalized and depreciated according to generally accepted accounting principles if the CMO has separately identifiable assets.

- Review the depreciation accounting if the CMO has separately identifiable assets recorded on the Balance Sheet.

3.12 Financial statement and data certification

Compliance Requirements: The Health and Community Supports Contract section X.1, Federal requirement 42 CFR 438.600, requires the CMO to assure the data submitted to the State is accurate, complete and truthful to the best of their knowledge by signing and submitting a Data Certification Form with each accepted batch of Encounter data and a Certification Form with each submitted Financial Statement.

Suggested audit procedures:

- Interview the staff person responsible for signing the attestation to assure that adequate controls and verification of the data exist in support of their attestation. Ask:
  - How do they know that the data is accurate, complete and truthful?
  - How often and who reviews the data?
  - What checks and balances are in place to assure data accuracy, completeness and truthfulness?

- One check and balance is a reconciliation from the claims and revenue ledgers (the information systems that transfer the data to Encounter reporting) to the general ledger accounts. Review that reconciliation to assure that this basis check is in place. This reconciliation should include:
  - Cost Share Revenue
  - Member Services (including provider payments and refunds)
  - Care Management services

3.13 Audits of service providers

Compliance requirement: Wis. Stat. 46.036(4) requires audits of service providers that receive $25,000 or more in department funding for the purchase of care and services, unless the audit is waived by the department. The CMO may request the waiver based on the risk assessment process described in the *Provider Agency Audit Guide* (on line at www.dhfs.state.wi.us/grants). Audits, if required, must meet the department's standards in the *Provider Agency Audit Guide* or the *State Single Audit Guidelines*.

Suggested audit procedures:

For a sample of the CMO's contracts with service providers, determine whether the CMO:

- Followed the *Provider Agency Audit Guide* when deciding whether to require an audit and, if so, the kind of audit.

- Performed the monitoring that it had planned to rely on so it could waive an audit or require a lesser-scoped audit than the risk would have otherwise indicated.
- Has a written waiver of the audit requirement from the department for all audits that were waived.
- Collected all audits due to the CMO by 180 days of the provider's fiscal year end, unless an extension was authorized.
- Reviewed all audits to determine whether the audit met the applicable audit standards.
- Identified and resolved any issues in the audit that affected the CMO's contract with the provider.

For CMOs that are operated by a county, the provisions in this section may be tested as part of the testing for the county's purchase of service function.